SERFF Tracking Number:	*BNLI-126648638*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45801*
Company Tracking Number:	*BNL-2010-3*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental*		
Project Name/Number:	*Individual Dental/BNL-2010-3*		

Filing at a Glance

Company: Brokers National Life Assurance Company

Product Name: Individual Dental	SERFF Tr Num: BNLI-126648638	State: Arkansas
TOI: H10I Individual Health - Dental	SERFF Status: Closed-Approved-Closed	State Tr Num: 45801
Sub-TOI: H10I.000 Health - Dental	Co Tr Num: BNL-2010-3	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Amy Irby, Mandi Rodriguez, Holly Harrison, Robin Salkowski	Disposition Date: 08/06/2010
	Date Submitted: 05/27/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Individual Dental	Status of Filing in Domicile: Pending
Project Number: BNL-2010-3	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Arkansas is our Domicile and these are Arkansas specific Changes
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/06/2010	Explanation for Other Group Market Type:
	State Status Changed: 08/06/2010
Deemer Date:	Created By: Mandi Rodriguez
Submitted By: Mandi Rodriguez	Corresponding Filing Tracking Number:

Filing Description:

The following referenced forms are being submitted for your review and approval.

Individual Dental Policy IDP(2000)
Individual Dental Amendment AMDID-AR(2010)

SERFF Tracking Number:	*BNLI-126648638*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45801*
Company Tracking Number:	*BNL-2010-3*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental*		
Project Name/Number:	*Individual Dental/BNL-2010-3*		

The above forms are being filed to comply with Rule 21, Coordination of Benefit Changes effective July 1, 2010. IDP(2000) was previously approved on 11/7/2000. Please note we are only making the required Coordination of Benefit changes and no other changes have been made.

Form # AMDID-AR(2010) will be used to amend all existing IDP(2000) policies to comply with Rule 21.

If you have any questions, please contact me at 800-798-1125, extension 1402, or email me at amy@bnlac.com.

Sincerely,

Amy Irby
Compliance Assistant

Company and Contact

Filing Contact Information

Mandi Rodriguez, Senior Compliance Assistant	mandi@bnlac.com
7010 Hwy 71 West	800-798-1125 [Phone] 1401 [Ext]
Suite 100	512-383-8502 [FAX]
Austin, TX 78735	

Filing Company Information

Brokers National Life Assurance Company	CoCode: 74900	State of Domicile: Arkansas
7010 Hwy 71 West	Group Code:	Company Type:
Suite 100	Group Name:	State ID Number:
Austin, TX 78735	FEIN Number: 63-0483783	
(800) 798-1125 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	$50.00 per filing

SERFF Tracking Number:	*BNLI-126648638*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45801*
Company Tracking Number:	*BNL-2010-3*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental*		
Project Name/Number:	*Individual Dental/BNL-2010-3*		
Per Company:	No		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Brokers National Life Assurance Company	$50.00	05/27/2010	36853687
Brokers National Life Assurance Company	$100.00	06/01/2010	36928767

SERFF Tracking Number:	*BNLI-126648638*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45801*
Company Tracking Number:	*BNL-2010-3*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental*		
Project Name/Number:	*Individual Dental/BNL-2010-3*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/06/2010	08/06/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	06/01/2010	06/01/2010	Mandi Rodriguez	06/01/2010	06/01/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Consumer Explanatory Booklet-COB	Mandi Rodriguez	05/27/2010	05/27/2010
Supporting Document	Flesch Certification for Consumer Explanatory Booklet-COB	Mandi Rodriguez	05/27/2010	05/27/2010

SERFF Tracking Number:	*BNLI-126648638*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45801*
Company Tracking Number:	*BNL-2010-3*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental*		
Project Name/Number:	*Individual Dental/BNL-2010-3*		

Disposition

Disposition Date: 08/06/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*BNLI-126648638*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45801*
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TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental*		
Project Name/Number:	*Individual Dental/BNL-2010-3*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Flesch Certification for Consumer Explanatory Booklet-COB	Approved-Closed	Yes
Form	Individual Dental Policy	Approved-Closed	Yes
Form	Individual Dental Amendment	Approved-Closed	Yes
Form	Consumer Explanatory Booklet-COB	Approved-Closed	Yes

SERFF Tracking Number:	*BNLI-126648638*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45801*
Company Tracking Number:	*BNL-2010-3*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental*		
Project Name/Number:	*Individual Dental/BNL-2010-3*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/01/2010
Submitted Date	06/01/2010
Respond By Date	07/01/2010

Dear Mandi Rodriguez,

This will acknowledge receipt of the captioned filing.

Objection 1

- Individual Dental Policy, IDP(2000) (Form)

Comment:

Our filing fees under Rule and Regulation 57 has been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $150.00. Please submit an additional $100.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*BNLI-126648638*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45801*
Company Tracking Number:	*BNL-2010-3*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental*		
Project Name/Number:	*Individual Dental/BNL-2010-3*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/01/2010
Submitted Date	06/01/2010

Dear Rosalind Minor,

Comments:

Response 1

Comments: Please see "Filling Fees" Tab, we have attached additional fees of $100.00 to this filing.

Related Objection 1

Applies To:

- Individual Dental Policy, IDP(2000) (Form)

Comment:

Our filing fees under Rule and Regulation 57 has been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $150.00. Please submit an additional $100.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Amy Irby, Holly Harrison, Mandi Rodriguez, Robin Salkowski

SERFF Tracking Number:	*BNLI-126648638*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45801*
Company Tracking Number:	*BNL-2010-3*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental*		
Project Name/Number:	*Individual Dental/BNL-2010-3*		

Amendment Letter

Submitted Date: 05/27/2010

Comments:

Please see the attached Consumer Explanatory Booklet for Coordination of Benefits. This is being filed to comply with the Coordination of Benefit changes required of Rule 21 effective July 1, 2010. The booklet will be given to new policyholders and at renewal.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
CEB-COB(2010)AR	Other	Consumer Explanatory Booklet-COB	Initial					CEB-COB(2010)AR.pdf

Supporting Document Schedule Item Changes:

User Added -Name: Flesch Certification for Consumer Explanatory Booklet-COB

Comment:

Flesch Certification for Consumer Explanatory Booklet-COB.pdf

SERFF Tracking Number:	*BNLI-126648638*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45801*
Company Tracking Number:	*BNL-2010-3*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental*		
Project Name/Number:	*Individual Dental/BNL-2010-3*		

Form Schedule

Lead Form Number: IDP(2000)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/06/2010	IDP(2000)	Policy/Contract/Fraternal Certificate	Individual Dental Policy	Initial			IDP(2000) pgs 1-7.pdf IDP(2000) pgs 8-15.pdf
Approved-Closed 08/06/2010	AMDID-AR(2010)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Individual Dental Amendment	Initial			AMDID-AR(2010).pdf
Approved-Closed 08/06/2010	CEB-COB(2010)AR	Other	Consumer Explanatory Booklet-COB	Initial			CEB-COB(2010)AR.pdf

BROKERS NATIONAL
LIFE ASSURANCE COMPANY

INDIVIDUAL DENTAL POLICY
PROVIDING DENTAL EXPENSE BENEFITS

POLICY NUMBER:	[100000]
INSURED'S NAME:	[JOHN DOE]
COVERED DEPENDENTS:	[NO DEPENDENT COVERAGE]
POLICY EFFECTIVE DATE:	[NOVEMBER 1, 2010]
STATE OF DELIVERY:	ARKANSAS

The premium you paid and the application you completed put this policy in force as of the policy effective date shown on the policy schedule. A copy of your application is attached.

IMPORTANT- PLEASE READ

Your application is a part of this policy. This policy was issued to you on the basis that all information in the application is correct and complete. PLEASE READ the copy of your application. If it is not correct or if any information has been left out, please write to us.

20 DAY RIGHT TO EXAMINE POLICY

It is important that you are satisfied with this policy and it meets your insurance needs. If you are not satisfied, send it back to us within twenty days after you receive it. We'll return your money. Then it was never in force.

RENEWAL AGREEMENT

We will renew this policy except for the following reasons:

- Nonpayment of the required premium payment; or
- fraud or intentional misrepresentation of material fact by a covered person; or
- We no longer offer policies of this type in your state.

PREMIUMS SUBJECT TO CHANGE

Your premium amount may be changed if changed on all policies of this form in the state where you live. If changed, your premium will be determined by your class on the policy effective date. Premium changes will be effective on your next renewal date.

Kenneth D. Tobey — President

Pam Randolph — Secretary

Home Office: 7530 Hwy 107, Sherwood, AR 72120
Administrative Office: 7010 Hwy 71 West, Suite 100, Austin, Texas 78735
Phone: 512-383-0220

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

POLICY NUMBER: [20,000]
INSURED NAME: [JOHN DOE]
COVERED DEPENDENTS: [NO DEPENDENT COVERAGE]
POLICY EFFECTIVE DATE: [NOVEMBER 1, 2007]
PLAN: [Individual Dental Plan A]

POLICY BENEFITS

Benefit Year Maximum (Per Covered Person) for Each Benefit Year ..... $ [1,000.00]

INSURANCE PERCENTAGE FIRST POLICY YEAR
Type I Expenses..... ... [80]% of covered expenses
Type II Expenses..... [0]% of covered expenses
Type III Expenses..... [0]% of covered expenses

INSURANCE PERCENTAGE SECOND POLICY YEAR
Type I Expenses..... ... [80]% of covered expenses
Type II Expenses.....[60]% of covered expenses
Type III Expenses.....[25]% of covered expenses

INSURANCE PERCENTAGE THEREAFTER
Type I Expenses ..... [80]% of covered expenses
Type II Expenses..... .. [60]% of covered expenses
Type III Expenses..... [50]% of covered expenses

ANNUAL DEDUCTIBLE- Accumulates on Benefit Year Basis
Maximum Benefit Year Deductible per Person per Benefit Year
Type I = $[50.00]; Type II = $[50.00]; and Type III = $[100.00]

WAITING PERIOD
Type I Expenses ..... [0] months
Type II Expenses..... ... [12] months
Type III Expenses..... ... [12] months

NOTE: Covered Dependent Children is defined on Page 4 of this policy.

[ORTHODONTIA
Orthodontic Care and Services are provided by form # IDPOR(2000) for Covered Dependents age 6 or older, but less than 19 years of age. Coverage is 50% of lesser of expenses incurred or Usual and Customary Charges.

Maximum Lifetime Benefit ..... $[1,000.00]
Waiting Period ..... [24] Months
Lifetime Deductible .....$[100.00]]

Monthly Premiums for first 12 months:

Insured Only:	$[28.40]
Insured and One:	$[54.60]
Insured and Family:	$[98.90]

Please mail all claims to our Claims Department:
Brokers National Life Assurance Company
Claims Department
P.O. Box 1028
Houston, Texas 77251

800-653-4427

DEFINITIONS OF IMPORTANT WORDS AND PHRASES

Benefit Year	Is a period of twelve (12) consecutive calendar months, beginning with the effective date of coverage for the covered person, and ending on the last day of the twelfth month.
Renewal Date	The date when your next premium is due.
Covered Dependent	An Insured's eligible dependent who is covered by the Policy.
Covered Person	An individual who is provided benefits under the Policy.
Dental Practitioner	Any licensed dentist, dental hygienist, denturist or licensed physician acting within the scope of such license.
Incur/Incurred	For an appliance or modification of an appliance, an expense shall be considered incurred at the time the impression is made. For a crown or bridge, an expense shall be considered incurred at the time the tooth or teeth are prepared. For root canal therapy, an expense shall be considered incurred at the time the pulp chamber is opened. All other expenses shall be considered incurred at the time service is rendered or a supply furnished.
Dental Care or Treatment	Means services or supplies for the teeth and their supporting tissues and structures (gums and alveolar process).
Surgical procedure	a. Involving an incision and /or excision of a dental structure and suturing of the wound; b. Biopsy of dental tissue or structure.
Policy Anniversary	The same date each year following the Policy Issue Date.
Waiting Period	The period of time between the date an Insured person is first covered under the Policy and the date benefits become payable.
We, Us and Our	Means Brokers National Life Assurance Company.
You, Your	Means the Insured as shown on Page three.

DEPENDENT COVERAGE

ELIGIBLE DEPENDENTS

The insured's Eligible Dependents are your lawful spouse and your unmarried dependent children who:

1. are less than Age 19;
2. are mainly dependent upon you for support and maintenance; and
3. live with you in a normal parent-child relationship.

"Children" include your step-children and adopted children or any child for whom you are a legal guardian or have filed a petition to adopt. Coverage for an adopted child shall be effective upon the earlier of: (a) the date of placement for the purpose of adoption; or (b) the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage will continue on the same basis as coverage for other dependent children, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

An Insured's newborn child will be covered from the date of birth as long as the Insured already has family coverage.

Your unmarried dependent children who are between Age 19 and Age 23 may be covered by the Policy if:

1. they are still dependent upon the employee for support and maintenance; and
2. they are attending an accredited high school or college as a full-time student.

If an otherwise eligible dependent child is an Eligible Dependent of two or more eligible insureds, the child is deemed to be an Eligible Dependent of only one Insured.

WHEN COVERAGE BEGINS

EFFECTIVE DATE OF COVERAGE

Your policy will take effect the first of the month following the date the following conditions are met:

- the application and required premium are received by us at the Administrative Office; and
- your answers on the application are complete and meet the requirements for acceptance.

Coverage for any Eligible Dependent will become effective only on or after the date you become insured.

BENEFIT PROVISIONS

COVERED BENEFITS

Subject to the waiting period and if a Covered Person incurs Type I, II or III Expenses while insured by the Policy, We will pay benefits in accordance with the Schedule of Benefits.

BENEFIT YEAR MAXIMUM

The Benefit Year Maximum is the maximum amount of benefits We will pay for Type I, II or III Expenses in any single Benefit Year. It applies separately to each Covered Person. The maximum is shown on the Schedule of Benefits.

DEDUCTIBLE

The Deductible is the initial amount of Covered Expenses in any benefit year for which no benefits are payable. It applies separately to each Covered Person each Benefit Year. The Deductible is shown on the Schedule of Benefits.

There is no maximum Deductible limit per family per benefit year. The deductible(s) must be paid by the Insured.

USUAL AND CUSTOMARY CHARGES

Usual and Customary Charges means those charges or portion of charges that do not exceed the usual amount charged in the locality where the expense was incurred. Such charges must be:

1. for necessary care and treatment of the Covered Person;
2. in keeping with the extent of the care and treatment provided; and
3. not in excess of the charge usually made for such services or treatment by Dental Practitioners in the same geographical area.

PRE-DETERMINATION OF BENEFITS

If the cost of planned dental treatment or supplies can reasonably be expected to exceed $300.00, We will pre-determine the benefits payable under the Policy. In order for Us to perform this service, the Insured must submit to Us a claim form showing the treatment proposed and the related fees. This claim form must be completed by the Dental Practitioner performing the treatment and be received by Us prior to the time treatment starts. We will determine which of the expenses for the proposed course of treatment qualify as Covered Expenses and advise the Dental Practitioner as to what benefits are payable.

Pre-determination of benefits does not guarantee payment. Benefits actually paid will be based on the benefits, if any, for which the Covered Person qualifies at the time the treatment or service is rendered.

COVERED EXPENSES

Subject to the terms and conditions of the Policy, Covered Expenses means the lesser of the charges actually incurred or the Usual and Customary Charges for the following treatments, services and supplies provided that the treatment, service or supply:

1. is received by a Covered Person while insured by the Policy;
2. is generally recognized by the dental profession as necessary for treatment of the condition; and
3. is rendered or prescribed by a Dental Practitioner.

TYPE I COVERED EXPENSES - PREVENTIVE AND DIAGNOSTIC

Charges for the following treatments, services and supplies are deemed Type I Covered Expenses, provided the conditions as defined in Covered Expenses are met:

1. oral examinations and prophylaxis, once in any six (6) consecutive month period;
2. x-ray services including full mouth x-rays or panoramic/panorex x-rays once in a thirty-six (36) consecutive month period, and one (1) bitewing x-ray series in any six (6) consecutive month period;
3. single film x-rays, and any x-rays not listed above;
4. topical application of fluoride for Covered Dependents under 19 years of age, once in any twelve (12) consecutive month period;
5. sealant applications for Covered Dependents under 19 years of age, once in a thirty-six (36) consecutive month period, limited to permanent molars only; and
6. space maintainers for Covered Dependents under 16 years of age.

TYPE II COVERED EXPENSES - BASIC RESTORATIVE AND CORRECTIVE

Charges for the following treatments, services and supplies are deemed Type II Covered Expenses, provided the conditions defined in Covered Expenses are met:

1. amalgam, silicate, plastic, acrylic or composite restorations (fillings) of primary or permanent teeth;
2. oral surgery including simple extractions, surgical removal of erupted teeth involving tissue flap and bone removal (Impacted Extractions are not covered under Type II Coverage);
3. anesthesia, if medically necessary, in conjunction with surgical procedures (will be coordinated with medical insurance coverage);
4. prescription medication necessary for relief of pain or control of infection; and
5. emergency palliative (pain relieving) treatment.

TYPE III COVERED EXPENSES - MAJOR RESTORATIVE AND CORRECTIVE

Charges for the following treatments, services and supplies are deemed Type III Covered Expenses, provided the conditions defined in Covered Expenses are met:

1. periodontic services (treatment of the gums) including gingival curettage, periodontal scaling and planing and periodontal prophylaxis;

2. endodontic procedures including root canal therapy, pulp capping and vital pulpotomy;

3. adjustments to fixed bridges and dentures (including relining and rebasing of dentures once in any twelve (12) consecutive month period), re-attachment of damaged or broken clasps, and adjustments to a denture more than six (6) months after installation;

4. inlays involving single or multiple surfaces;

5. crowns and posts including acrylic, acrylic processed to metal, porcelain, porcelain fused to metal, full cast metal, and full cast gold;

6. installation of prosthodontics including complete upper denture, complete lower denture, fixed bridges, and partial dentures having acrylic base with two clasps to replace natural teeth (excluding third molars) which were lost after the effective date of coverage of the Covered person;

7. repairs to dentures including broken teeth, fixed bridges, simple stress breakers and addition of teeth to replace extracted natural teeth; and

8. surgical procedures including periodontal surgery, removal of impacted teeth and related anesthesia (oral surgery and cutting procedures will be coordinated with any medical insurance coverage).

The replacement of an existing prosthodontics device will be deemed a Covered Expense only if at least one of the following conditions is met:

1. the replacement appliance replaces an existing appliance which is at least five years old and cannot be made serviceable;

2. the existing appliance is temporary in nature and was installed after the date the Covered Person became insured and cannot be made permanent, and is replaced within 12 months by the permanent appliance. (Note: If the temporary is not replaced within 12 months by the permanent appliance, the temporary will then be considered a permanent placement and subject to the plan's frequency limitations.)

3. the replacement appliance is required as the result of accidental bodily injury which occurs after the date the Covered Person became insured (accidents will be coordinated with medical insurance coverage).

WHAT IS NOT COVERED BY THE POLICY

Policy benefits will not be payable for any expense incurred for or in connection with:

A. charges for taxes and discounts;

B. dental care for which the Covered Person would not be required to pay if there were no insurance;

C. dental care provided only for the purpose of improving appearance (cosmetic dentistry) when form and function of the teeth are satisfactory and no pathological condition exists, including but not limited to the following: (a). Composite restorations, veneers, facings or similar properties of crowns or pontics placed on or replacing teeth in back of the first bicuspid; or (b). Personalization or characterization of dentures;

D. dental care below the standards accepted by the American Dental Association;

E. charges in excess of the Usual and Customary Charge for the least expensive alternate service or materials consistent with adequate dental care (this applies when such alternative services or materials are customarily provided);

F. charges for appointments not kept, office calls if no other service is performed and charges for completion of claim forms;

G. appliances, restorations, treatment or procedures for: (a). Altering vertical dimension; (b). Restoring or maintaining occlusion; (c). Splinting; (d). Replacing tooth structure lost from attrition or abrasion; or (e). Temporomandibular Joint Syndrome (TMJ) disorders;

H. charges for periodontal probing and charting;

I. charges for services and supplies of the type normally intended for sport or home use;

J. charges relating to dental care directly or indirectly caused by: (a). war, insurrection or hostile action of the armed forces of any country; or (b). any cause for which indemnity or compensation is paid under any Workers' Compensation Law or similar legislation;

K. charges for replacing a lost, missing or stolen device or appliance;

L. charges for services begun before or provided prior to the date the Covered Person became insured and charges for services provided after termination of insurance of the Covered Person under the Policy;

M. dietary planning, oral hygiene training in preventive dental care and infection control;

N. services rendered as a result of injuries suffered while patient is: (a). committing or attempting to commit a felony; (b). engaging in an illegal occupation; or (c). participating in a riot, rebellion or insurrection;

O. analgesia, nitrous oxide and desensitization when not related to oral surgery;

P. experimental procedures;

Q. hospital costs and additional fees charged by the Dental Practitioner for hospital treatment;

R. surgical procedures for correction of malalignment of teeth and/or jaws;

S. charges for implantology including implants and appliances;

T. charges incurred for defective parts or workmanship replaced within six (6) months;

U. services provided or paid for by a government agency or under any government program or law except as to charges which the person is legally obligated to pay (the exception extends to any benefits provided under the U.S. Social Security Act of 1965 (Medicare) and its amendments or for dental care furnished while a person is confined in a hospital operated by the U. S. Government or its agency or a state supported institution) except Medicaid;

V. dental care for a congenital or developmental malformation not limited to but including, congenitally missing teeth;

W. temporary restoration; however, if the temporary restoration is part of a course of treatment, the maximum benefit for a permanent restoration will include the fee for the temporary restoration;

X. charges for any duplicate services, devices, or appliances, including prosthetics;

Y. procedures which are medical in nature; or

Z. any item which is not listed as a Covered Expense.

NOTE: Orthodontic treatment, unless specifically provided for on the Schedule of Benefit Page and by a Rider attached to the Policy, is not covered by the plan.

TERMINATION OF INSURANCE

INSURED

The Insured's insurance under the Policy will terminate on the earliest of the following dates:

1. the date the Policy lapses for non-payment of premium; or
2. fraud or intentional misrepresentation of material fact by a covered person; or
3. We elect to no longer offer policies of this type in your state.

COVERED DEPENDENTS

An Insured's Covered Dependent(s) insurance under the Policy will end on the earliest of the following dates:

1. the date the Insured's insurance is terminated;
2. the date the Policy is amended so as to terminate the dependent's insurance;
3. the date the Covered Dependent enters the military service of any country or international organization;
4. the last day of any policy month in which any required premium for the Covered Person's insurance is not paid; and
5. the date the dependent ceases to be an Eligible Dependent except as may be waived by the "Continuation of Dependent Child Insurance After Age 19" provision.

TERMINATION DOES NOT AFFECT EXISTING CLAIM

When a Covered Person's insurance is terminated for any reason, it does not affect any claim for Covered Expenses which were incurred while the Covered Person's insurance was in force.

CONTINUATION OF INSURANCE

CONTINUATION OF COVERAGE FOR SPOUSE

A covered spouse will become the insured under this policy if you die or become eligible for Medicare. Coverage will not change. The continuation of coverage is subject to the Renewal Agreement.

CONTINUATION OF DEPENDENT CHILD INSURANCE AFTER AGE 19

Subject to the other terms and conditions of the Policy, insurance for any unmarried dependent child whose insurance is terminating because he or she reached age 19 (age 23 if attending an accredited high school or college as a full-time student) may be continued at the child premium rate if:

1. the child is incapable of self support due to a mental or physical handicap;
2. the child's incapacity started while insured under the Policy and prior to age 19;
3. the child is primarily dependent on the Insured for support and maintenance;
4. a request for continuation and satisfactory proof of the child's incapacity is presented to Us; or
5. any required premium is paid.

Such continued insurance will end on the earliest of:

1. the date the child's incapacity ends;
2. the last day of any policy month in which the Insured fails to provide any required proof or fails to pay any required premium; or
3. when the Insured's insurance ends.

CLAIM PROVISIONS

NOTICE OF CLAIM

Written notice of claim must be given to Us within thirty (30) days after the occurrence of any loss or the beginning of any treatment covered by the Policy. Notice given by or on the behalf of the Insured to Our Claims Department, with sufficient information to identify the Covered Person on whom a claim is based will be deemed notice to Us.

Failure to give Us notice within the time required will not act to reduce or invalidate any claim if it can be shown that it was not reasonably possible to do so and that notice was given as soon as was reasonably possible.

CLAIM PROVISIONS (Continued)

PROOF OF LOSS

Written proof of loss must be given to Us within ninety (90) days after the date of such loss or at the start of any treatment for which We are liable. We may, at Our option, require supporting proof of loss such as clinical reports, charts, x-rays and study models.

Failure to furnish such proof within the time required will not act to reduce or invalidate any claim if it can be shown that it was not reasonably possible to furnish such proof and that proof was furnished as soon as was reasonably possible. In any case, proof must be filed within one year unless the Insured is legally incapacitated.

EXAMINATION

We have the right, at Our expense, to have anyone on whom a claim is based to be examined by a Dental Practitioner of Our choice during the pendency of the claim.

TIME LIMITS

If any time limit in the Policy is less than permitted by law in the state where it is issued, it is hereby extended to agree with the minimum required by such law.

ASSIGNMENT OF BENEFITS

Policy benefits may be assigned to a third party. Any assignment will be effective on the date it is assigned, subject to any actions We may take prior to Our receipt of the assignment. We assume no responsibility for the validity of an assignment.

PAYMENT OF BENEFITS

Subject to the "Coordination of Benefits" and "Facility of Payment" provisions, all policy benefits are payable in the following order immediately upon Our receipt of proof of loss:

1. to any assignee of record; otherwise
2. to the Insured, if living; otherwise
3. to the Insured's estate.

TIME OF PAYMENT

An eligible claim shall be paid upon receipt of acceptable written proof of loss.

FACILITY OF PAYMENT

If any policy benefits become payable to anyone who, in Our opinion, is legally incapable of giving Us a valid receipt or release, We may pay a portion of such benefits to any individual or institution We believe has assumed custody or principal support for such person, provided:

1. We have not received a request for payment from the person's legal guardian or other legally appointed representative; and
2. the total payments do not exceed $1,000.00.

ACTION AT LAW

No action at law or in equity may be brought to recover on the Policy until sixty (60) days after proper written proof of loss has been given Us. No such action may be brought at all after a period of three years from the time such proof is required to be furnished.

MEDICAID/STATE MEDICAL ASSISTANCE PROGRAMS

If any policy benefits become payable for any Covered Expenses which are covered by Medicaid or any similar state medical assistance programs, We will pay such benefits to the governmental agency or department charged with administering such programs, if required by law. We will pay the benefits as if the insured person has assigned the benefits to the agency or department. Any payment made by Us in accordance with this provision will fully discharge Our liability with respect to the payment of such benefits.

"Medicaid" means the Medical Assistance Act of 1967 as then enacted or later amended.

OTHER POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES

The Policy, Your application (a copy of which is attached) form the entire contract of insurance. We may change the terms and conditions of the Policy. Any change must be made in writing and signed by one of Our officers. No agent may change, alter or waive any of the terms and conditions of the Policy.

MISSTATEMENTS

All statements made in an application by You will, in the absence of fraud, be deemed representations and not warranties. No statement made by You will be used in any contest of the Policy or to deny a claim unless:

1. it is contained in a written statement signed by You; and
2. a copy of such statement has been given to You.

No statement, except a fraudulent misstatement, will be used to:

1. contest the Policy after it has been in force for two years; or
2. deny a claim on a Covered Person who has been insured by the Policy for two years.

OTHER INSURANCE WITH US

A covered person may only have one policy with us that is comparable to this policy. If, through an error, we issue more than one policy, you may select which policy will remain in force. We will refund the money you or a covered person paid on any other policy, less the amount of claims paid.

PREMIUM

You must pay all policy premiums in advance. The amount of each premium due under the Policy will be the sum of premiums applicable to each Covered Person. Premiums may be paid annually or monthly. Each premium is payable to our Administrative Office.

Premium due dates and the premium rates applicable are shown in the Schedule of Benefits; unless otherwise changed.

OUR RIGHT TO CHANGE PREMIUM RATES

We have the right to change Our premium rates from time to time after the Policy has been in force for one year, but not more often than once every six months. We may change Our rates for the Insured or Insured's Dependent(s). We will give You at least Sixty (60) days prior written notice of any change. Your premium amount may be changed if changed on all policies of this form in the state where you live. If changed, your premium will be determined by your class on the Policy Effective Date. Premium changes will be effective on your next Renewal Date.

GRACE PERIOD

Unless You have given Us prior written notice that the Policy is to be discontinued, We will allow a thirty-one (31) day grace period for the payment of each policy premium after the first premium. The grace period will be measured from the premium due date. During the grace period, the Policy will stay in force. If the premium is not paid by the end of the grace period, the Policy will terminate. If the Policy is terminated, You must pay the pro rata premium for the days of grace.

TERMINATION OF THE POLICY

The Policy will automatically terminate at the end of a grace period if the premium is not paid.

After the Policy has been in force for at least twelve (12) months, We may terminate the Policy or terminate the coverage of any Covered Persons by Class on any policy anniversary.

If We terminate the Policy, We will give You at least thirty-one (31) days prior written notice.

You may terminate the policy on any premium due date by giving Us at least thirty-one (31) days prior written notice.

OTHER POLICY PROVISIONS (Continued)

REINSTATEMENT OF LAPSED POLICY

If any renewal premium is not paid within the time allowed for payment and we accept a premium without requiring an application for reinstatement, that payment shall reinstate this policy. If we require an application, this policy will be reinstated when we approve it. If we do not approve the application, this policy will be reinstated on the 45th day after the date of the application unless we notify you in writing of its disapproval. The reinstated policy only covers dental covered expenses incurred after the date of reinstatement.

In all other respects, you and we shall have the same rights under the policy as we had before it lapsed, unless there are special conditions that apply to the reinstatement. If there are, they will be endorsed on or attached to the policy. Any premium accepted to reinstate the policy will be used for the period for which premium had not been paid before. However, it will not be used for any period more than 60 days before the date of reinstatement.

CHOICE OF DENTAL PRACTITIONER

Each Covered Person has the right to use any Dental Practitioner of choice.

CONFORMITY WITH STATE STATUTES

If any provisions of the Policy do not conform to the statutes of the state of delivery on the effective date of the Policy, such provisions are hereby amended to meet that state's minimum requirements.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans does not exceed 100% of the total allowable expense.

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is not covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in case of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other plan.

B. (1) Except as provided in paragraph (2), a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

D. Each plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
- If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The plan covering the custodial parent;
- The plan covering the spouse of the custodial parent;
- The plan covering the non-custodial parent; and then
- The plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one plan of individuals who are parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-Off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation of Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Brokers National Life Assurance Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Brokers National Life Assurance Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Brokers National Life Assurance Company any facts it needs to apply those rules and determine benefits payable.

COORDINATION OF BENEFITS (Continued)

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Brokers National Life Assurance may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Brokers National Life Assurance Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Brokers National Life Assurance Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

BROKERS NATIONAL

LIFE ASSURANCE COMPANY

Individual Insurance Policy
Providing Dental Expense Benefits

AR

BROKERS NATIONAL LIFE ASSURANCE COMPANY
INDIVIDUAL DENTAL INSURANCE
AMENDMENT TO POLICY

INSURED'S NAME:
POLICY NUMBER:

The above referenced Individual Dental Insurance Policy is hereby amended as follows:

The **"COORDINATION OF BENEFITS"** provision has changed to:

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans does not exceed 100% of the total allowable expense.

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is not covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in case of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

(A) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other plan.

(B) (1) Except as provided in paragraph (2), a plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(C) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

(D) Each plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
- If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The plan covering the custodial parent;
- The plan covering the spouse of the custodial parent;
- The plan covering the non-custodial parent; and then
- The plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one plan of individuals who are parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-Off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation of Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Brokers National Life Assurance Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Brokers National Life Assurance Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Brokers National Life Assurance Company any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Brokers National Life Assurance may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Brokers National Life Assurance Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Brokers National Life Assurance Company is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

This Amendment is issued the later of July 1, 2010 or the policy effective date and is hereby made a part of the Policy referenced.

BROKERS NATIONAL LIFE ASSURANCE COMPANY

Tammy Barr

Vice President-Underwriting

CONSUMER EXPLANATORY BOOKLET

COORDINATION OF BENEFITS

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determine your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If you situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary.

When This Plan is Primary

If you or a family member are covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child's Expenses

- The claim is for the health care expenses of your child who is covered by this plan and
  - You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is know as the "birthday rule"; or
  - You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses; or
  - There is no court decree, but you have custody of the child.

Other Situations

We will be primary when other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits in accordance with the terms of your contract, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

How We Pay Claims When We Are Secondary

When we are the secondary plan, we do not pay until the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a health care expense covered by one of the plans, including copayments, coinsurance and deductibles.

- If there is a difference between the amount the plan allows, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the primary plan, whichever is higher. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their providers.

- We will determine our payments by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We may reduce our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid do not exceed the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other health care coverage toward our own plan deductible.

- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.

- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefits because you did not obtain pre-certification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

Questions About Coordination of Benefits?
Contact Your State Insurance Department

ARKANSAS INSURANCE DEPARTMENT
1200 WEST THIRD STREET
LITTLE ROCK, AR 72201
1-800-852-5494

SERFF Tracking Number:	*BNLI-126648638*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45801*
Company Tracking Number:	*BNL-2010-3*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental*		
Project Name/Number:	*Individual Dental/BNL-2010-3*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	08/06/2010
Comments:			
Attachment:			

Flesch Readability Certification-Ind Dental.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	08/06/2010
Comments:			
Attachment:			

List of Prev Approved Apps-Ind Dental.pdf

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	08/06/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	08/06/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification for Consumer Explanatory Booklet-COB	Approved-Closed	08/06/2010
Comments:			
Attachment:			

SERFF Tracking Number:	*BNLI-126648638*	*State:*	*Arkansas*
Filing Company:	*Brokers National Life Assurance Company*	*State Tracking Number:*	*45801*
Company Tracking Number:	*BNL-2010-3*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental*		
Project Name/Number:	*Individual Dental/BNL-2010-3*		

Flesch Certification for Consumer Explanatory Booklet-COB.pdf

BROKERS NATIONAL LIFE ASSURANCE COMPANY

Readability Certification

This is to certify that the below listed forms meet the minimum Flesch Reading Ease Score as required by ACA 23-80-206.

Form #	**Flesch Reading Ease Score**
IDP(2000)	54
AMDID-AR(2010)	46

Tammy Barr
Vice President-Underwriting

5/26/2010
Date

List of Previously Approved Applications

Form #	**Date Approved**
IDA(2004)	3/22/2004

BROKERS NATIONAL LIFE ASSURANCE COMPANY

Readability Certification

This is to certify that the below listed form meets the minimum Flesch Reading Ease Score as required by ACA 23-80-206.

Form #	**Flesch Reading Ease Score**
CEB-COB(2010)AR	65

Tammy Barr
Vice President-Underwriting

5/26/2010
Date